# National Provider Identifier (NPI) Collection Form
# (Individual/ Solo Practices)

Any form not containing all required fields will be rejected.

## Section 1 – Provider General Information
## (Please make additional copies if required)

| Provider Last Name | First Name | Middle | Title |
|---|---|---|---|
| | | | |

| Existing Medicaid ID's | SSN | EIN Number |
|---|---|---|
| | | |
| | | |
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| | | |
| | | |
| | | |

## Section 2 – NPI Information

**NPI Number** _____

**Taxonomy Codes**

| | | |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## Section 3 – Primary Practice Location (As Entered on NPPES)

**Address** _____

| City | State | ZIP |
|---|---|---|
| | | |

| Phone Number | Fax Number | Provider e-mail Address |
|---|---|---|
| | | |

## Section 4 – Contact Information

**Name of Individual Completing Form** _____

| Phone Number | Fax Number | Contact e-mail Address |
|---|---|---|
| | | |

**Signature** _____ **Title** _____

**NPI Collection Form Surety Statement:**
**"I certify that the information provided on this application is complete and correct to the best of my knowledge."**

# Instructions
# Individual/Solo Practice

Send the completed NPI Collection Form and a copy of the NPPES confirmation via one of the following means:

| | |
|---|---|
| **Mail** | Provider Enrollment<br>Attn: NPI Collection<br>310 Great Circle Rd.<br>Nashville, TN 37243 - 1700 |
| **Fax** | (615) 248-4386 or (866) 456-8059 |
| **Field** | **Instruction** |
| **Section 1 – Provider General Information** | |
| Provider Last Name | (Required) Enter the provider's last name. |
| First Name | (Required) Enter the provider's first name. |
| Middle | (Optional) Enter the provider's middle name. |
| Title | (Required) Enter the provider's title. |
| Existing Medicaid ID's | (Required) Enter all currently assigned Medicaid provider numbers. |
| SSN | (Required) for an individual provider. Enter the Social Security Number. |
| EIN Number | (Required) Enter the Employer Identification Number (could be SSN). |
| **Section 2 – NPI Information** | |
| National Provider Identifier | (Required) Enter the National Plan and Provider Enumeration System (NPPES) assigned NPI. |
| Taxonomy Codes | (Required) Enter the Taxonomy codes associated with the assigned NPI. |
| **Section 3 – Primary Practice Location** | |
| Address | (Required) Enter the primary practice location line 1 address of the provider as entered in the NPPES. |
| City | (Required) Enter the primary practice location City of the provider as entered in the NPPES. |
| State | (Required) Enter the primary practice location State of the provider as entered in the NPPES. |
| ZIP | (Required) Enter the primary practice location ZIP of the provider as entered in the NPPES.<br>If known, include the ZIP +4. |
| Phone Number with area code | (Required) Enter the primary practice location phone number of the provider as entered in the NPPES. |
| Fax Number with area code | (Optional) Enter the primary practice location fax number of the provider as entered in the NPPES. |
| Provider e-mail Address | (Optional) Enter the primary practice location e-mail address of the provider as entered in the NPPES. |
| **Section 4 – Contact Information** | |
| Name of Individual Completing Form | (Required) Enter the name of the individual completing this form. |
| Phone Number with area code | (Required) Enter the phone number of the individual completing this form. |
| Fax Number with area code | (Optional) Enter the fax number of the individual completing this form. |
| Contact e-mail Address | (Optional) Enter the e-mail address of the individual completing this form. |
| Signature and Title | Signature and Title of the person who has legally binding authority to provide information to the Bureau of TennCare with regards to the provider identified on the form. |